HEALTH INSURANCE REFORM/Medical Savings Accounts (MSAs)

SUBJECT: **Health Insurance Reform Act of 1996 . . . S. 1028. Kassebaum second-degree perfecting amendment No. 3677 to the Dole/Roth amendment No. 3676.**

ACTION: AMENDMENT AGREED TO, 52-46

SYNOPSIS: As reported with an amendment in the nature of a substitute, S. 1028, the Health Insurance Reform Act of 1996, will make health insurance more accessible, portable, and renewable.

The Dole/Roth amendment would enact tax-related health care reforms as detailed below.

● Self-employed deduction: the deduction of health care expenses for the self-employed would be increased from the current 30 percent by 5 percent per year until it reached 80 percent in the year 2006, at which level it would remain.

● Long-term care insurance: long-term care insurance and expenses would be given the same deductibility as accident and health insurance contracts; long-term care policies would meet consumer protection standards to make sure that they paid adequately for quality long-term care when needed.

● Life-insurance withdrawals: terminally and chronically ill individuals would be permitted to make tax-free withdrawals from their life insurance policies to pay their medical expenses.

● Medical savings accounts (MSAs): individuals with high-deductible health plans ($1,500 or greater for an individual plan or $3,000 or greater for a family plan) and/or their employers would be allowed to make tax-free contributions to MSAs for those individuals (up to $2,000 per year for an individual and up to $4,000 per year for a family); tax-free distributions from MSAs would be allowed to meet medical expenses, including ophthalmological and dental expenses, long-term care, and Consolidate Omnibus Reconciliation Act of 1986 (COBRA) coverage (in general, COBRA coverage refers to the right of a worker to retain insurance offered through a job for 18 months after leaving that job; the worker pays 102 percent of the total premium that had been paid by the worker and employer); withdrawals for other than health purposes would be taxed and subject to a 10-percent penalty (unless the beneficiary had reached age 59.5, was disabled, or had died).

● Investment Retirement Account (IRA) withdrawals: penalty-free withdrawals from IRAs would be allowed to buy health and

(See other side)

YEAS (52)

Republicans (5 or 10%)	Democrats (47 or 100%)	
Bond	Akaka	Inouye
Chafee	Baucus	Johnston
Gorton	Biden	Kennedy
Hatfield	Bingaman	Kerrey
Kassebaum	Boxer	Kerry
	Bradley	Kohl
	Breaux	Lautenberg
	Bryan	Leahy
	Bumpers	Levin
	Byrd	Lieberman
	Conrad	Mikulski
	Daschle	Moseley-Braun
	Dodd	Moynihan
	Dorgan	Murray
	Exon	Nunn
	Feingold	Pell
	Feinstein	Pryor
	Ford	Reid
	Glenn	Robb
	Graham	Rockefeller
	Harkin	Sarbanes
	Heflin	Simon
	Hollings	Wellstone
		Wyden

NAYS (46)

Republicans (46 or 90%)		Democrats (0 or 0%)
Abraham	Inhofe	
Ashcroft	Jeffords	
Bennett	Kempthorne	
Brown	Kyl	
Burns	Lott	
Coats	Lugar	
Cochran	McCain	
Cohen	McConnell	
Coverdell	Murkowski	
Craig	Nickles	
D'Amato	Pressler	
DeWine	Roth	
Dole	Santorum	
Domenici	Shelby	
Faircloth	Simpson	
Frist	Smith	
Gramm	Snowe	
Grams	Specter	
Grassley	Stevens	
Gregg	Thomas	
Hatch	Thompson	
Helms	Thurmond	
Hutchison	Warner	

NOT VOTING (2)

Republicans (2)	Democrats (0)
Campbell-[2]	
Mack-[2]	

EXPLANATION OF ABSENCE:
1—Official Buisiness
2—Necessarily Absent
3—Illness
4—Other

SYMBOLS:
AY—Announced Yea
AN—Announced Nay
PY—Paired Yea
PN—Paired Nay

long-term care insurance and to pay for major medical expenses.

- High-risk pools: State-sponsored, high-risk health insurance pools would be tax-exempt.
- Medicare fraud: numerous reforms to reduce Medicare waste, fraud, and abuse would be enacted (as proposed by Senator Cohen and as agreed to by the Administration, health care providers, and consumer groups); these Medicare reforms would result in $3 billion in savings over 7 years.

To pay for the cost of the tax deductions that it would provide, the Dole/Roth amendment would enact the following offsets:

- tax rules on expatriates would be revised;
- thrift institutions would calculate their tax deduction for bad debts in the same manner as do banks;
- fraud in the Earned-Income Credit program would be reduced; and
- an interest deduction for loans with respect to company-owned insurance would be denied.

The Kassebaum second-degree perfecting amendment would strike the section on medical savings accounts from the Dole/Roth amendment.

Those favoring the Kassebaum amendment contended:

Argument 1:

We have three basic reasons for opposing favorable tax treatment for medical savings accounts (MSAs). First, such treatment would not help poorer Americans. The Joint Tax Committee has estimated that only 1 percent would go to people who earn less than $30,000. Further, 97 percent of the benefits would go to Americans earning more than the median family income. Thus, giving this favorable tax treatment would be the same as giving Federal welfare to wealthy Americans. Our second objection is that this tax treatment would encourage younger, healthier individuals to leave the insurance market. Such individuals would readily agree to buy only catastrophic coverage, because they could reasonably expect not to have many medical expenses, and could thus expect to be able to build up large surpluses in their medical savings accounts. In contrast, Americans who have thousands of dollars in medical bills yearly obviously would not want to rely on MSAs. The result would then be that much higher premiums would be paid by sicker, older Americans, because insurance companies would no longer be able to subsidize their benefits using the premiums from healthy, younger Americans who rarely get sick. Our third objection to providing this tax treatment is that we see it as a long-term assault on Medicare. We suspect our Republican colleagues hope eventually to offer MSAs as an alternative for Medicare. Offering that choice would undermine support for Medicare, and we are not willing to vote for any proposal that would undermine that support. Medicare must remain under Federal Government control and participation must remain mandatory. Everyone is aware of the controversy surrounding medical savings accounts. If the Kassebaum amendment fails, this bill will no longer have broad, bipartisan support. Numerous other controversial amendments will then be debated, and we are certain that many will be adopted. The end result will be that this bill will not be passable. We hope our colleagues oppose that result. We hope they will join us in approving the Kassebaum amendment.

Argument 2:

We can see both benefits and costs to the medical savings account provisions of the Dole/Roth amendment. We are certainly willing to give the issue more study. Because the issue is obviously so controversial, though, we are not willing to consider it on this bill. This bill, as drafted, has wide, bipartisan support. If we manage to keep it in this form, we are certain that it will be enacted. Adding on controversial elements will make it less likely that it will be enacted. We are not willing to risk that result, and thus must support the Kassebaum amendment to strike the medical savings account provisions.

Those opposing the amendment contended:

The Kassebaum amendment would strike the most important part of the Dole/Roth amendment, which is the section on medical savings accounts (MSAs). Support for MSAs was once bipartisan, but, as some of our Democratic colleagues have come to realize that providing equitable tax treatment for MSAs hurts their goal of socialized medicine, that bipartisanship has gradually evaporated. Though we are certain that at least a few of our Democratic colleagues still oppose socialized medicine and support MSAs, on this vote they are likely to move in lockstep with their party. Whether this vote carries or not, this issue is not dead. The House strongly supports MSAs, and we are confident that some form of them will survive any conference that is held on this bill.

Approving equitable tax treatment for MSAs as proposed in the Dole/Roth amendment would do little more than partially fix massive, and destructive, market distortions in the health care field that have been created by the Federal Government. Prior to World War II, individuals were responsible for their own medical care. They could pay for it out-of-pocket or they could buy insurance. Sliding-scale fees plus professional ethics assured that the poor received care. The Government was not involved. Wage and price controls during World War II began to change this system. Employers, pressed to find more workers under wartime boom conditions

but forbidden to offer higher money wages, started giving non-wage benefits. Employer-provided medical care proved particularly popular. As something new, it was not covered by existing tax regulations, so employers naturally treated is as exempt from the withholding tax. The Internal Revenue Service just as naturally assumed that it was taxable as income, and, naturally, it took it a few years to draw up the regulations saying so. By that time the practice had spread widely and workers were used to the idea that their employer-provided health benefits were tax exempt. Those workers protested against the regulations, and Congress responded by passing a law to exempt employer-provided medical care for employees from both the personal and corporate taxes.

This special tax treatment did not extend to people who purchased insurance on their own, nor did it help people who paid medical expenses out-of-pocket. The Federal Government was thus responsible for distorting the health care market by creating an extremely strong bias for gaining coverage through one's employer. In 1965, the Federal Government added yet another distortion when it created Medicaid and Medicare. As recently as 1960, 60 percent of medical expenses were paid by the patients themselves. Today, 80 percent of medical expenses are paid by somebody other than the patients themselves, with the Government's share standing at 46 percent.

Both employer-based insurance and Government-run medicine for the poor and elderly have brought immense problems. The largest problem with employer-based insurance is that it creates what is called "job lock." People who have medical problems cannot change employers or quit working without losing their insurance coverage, and if they have preexisting medical problems they cannot obtain new insurance. This bill will address the problem of job lock, and preexisting conditions in general, by making insurance "portable" (meaning that employees will have the right to continue their insurance coverage indefinitely after they leave employment, so long as they pay the full premium costs that were formerly paid by both them and their employers), and by limiting to a maximum of 12 months, and in most cases less, the time period during which coverage may be denied under an insurance policy for a preexisting condition that is covered by that policy.

For Medicare and Medicaid, the largest problem has been controlling runaway costs. There are numerous reasons why these programs have been growing at unsustainable rates. At the root of the problem is that command economies never run efficiently and effectively. Without competition and individual choice, the result is always poor service, expensive service, and bureaucratic service. Medicare and Medicaid are the one part of the health care system that is growing uncontrollably in the United States and they are the one part that is run by the Federal Government.

One problem that Government-run health care and employer-based insurance share is that they both encourage beneficiaries to use medical services. Beneficiaries contribute a set amount of money to a common pool, whether they use services or not, and they then receive medical services paid for out of that pool either for free or at a greatly subsidized rate. This arrangement obviously encourages more use of medical services. The Government and private insurers respond differently to this problem. Insurers discourage the liberal use of medical services because such use depletes their pools, forces them to raise premium rates, and thus costs them customers to competitors. The Federal Government, though, cannot be put out of business by competitors if it fails to hold down costs. In fact, for the past several decades it has been encouraged to increase costs by beneficiaries who have rewarded politicians at the polls when they have expanded benefits.

Last Congress, President Clinton and liberal Democrats in Congress tried to pass a plan that would have had the Government take over most of the private health care system, including by creating 4 new entitlements (one of which would have spent more than $1 trillion in 8 years), by imposing at least 17 new taxes, by creating 55 new Federal bureaucracies (one of which would have had the authority to impose price controls on health care), by imposing at least 177 new mandates on the States, by imposing at least 49 new mandates on employers, and by mandating a standard benefits package (see 103d Congress, second session, vote Nos. 287-291). The rationale for proposing this massive socialization of health care in America was to increase the insurance coverage rate to 95 percent from the then 89-percent rate. Democrats made this proposal because they were (and are) convinced that nationalizing health care would be good for America. The facts that the Government created the bias in favor of employer-insurance, which in turn is responsible for most of the uninsured in America, and that the one part of the health care industry that is run by the Government is by far the most troubled, did not concern them. Democrats will never let experience or facts interfere with their theories, because they so sincerely believe in their theories that they do not believe in any facts or experiences that prove their theories wrong.

When President Clinton and liberal Democrats made this proposal, Republicans and, to be fair, some Democrats pointed out that most people without insurance coverage are only temporarily without it due to job changes and/or due to problems obtaining it due to preexisting conditions. They argued, therefore, that we should address those problems instead of remaking the entire private health care industry in the image of Medicare and Medicaid, the runaway costs of which are literally bankrupting America. The Democrats' bill was defeated, and Republicans and Democrats began putting together this bill, which takes the commonsense approach that was advocated by Republicans in the debate last Congress.

Though this bill will fix the portability and preexisting condition problems of private, employer-based insurance, it will not fix the other Government-created problem, which is that an adversarial relation exists between employees who get more for their money the more they use medical services and insurers who benefit the more they can stop the use of medical services. The Dole/Roth MSA provisions would provide a workable, cost-effective solution to this problem. This good idea has come from the States, which have had great success with it in improving health care for their citizens while at the same time substantially lowering costs. MSAs are already in use in 17 States, and many more States have legislation pending on their adoption.

MSAs as proposed in the Dole/Roth amendment would remove the adversarial relationship between health care providers and their patients. Participants would be required to buy high-deductible insurance to cover major medical expenses. (Overuse of high-deductible policies is not a problem because they are not used unless beneficiaries have severe problems like severe spinal cord injuries; such beneficiaries seek treatment with or without policies that encourage them to use medical services.) With deductibles of $1,500 or more, most medical expenses would not be paid for at all by these policies, because trips to doctors offices, laboratory work, and most other medical expenses are usually much less than $1,500. To pay these high deductible amounts, participants would establish MSAs, which work the same as investment retirement accounts except that withdrawals are used for medical purposes only. Participants and their employers would be allowed to make tax-free contributions to MSAs, and withdrawals would also be tax-free. This arrangement would give MSAs the same treatment as is now given to employer-based insurance, the contributions to which and the withdrawals from which are both tax-free. The money in an MSA would not be part of a common pool of money; it would be the participant's. The participant, because he or she would be spending his or her own money, would not be encouraged to use as much of it as possible on minor medical services. The problem of the "global commons" would be removed once a participant was no longer drawing services out of a common pool of money.

Removing the adversarial relationship would result in savings for both employers and employees. A recent Cleveland University study of 27 Ohio firms that offer both MSAs and traditional insurance policies found that the MSAs resulted in substantial savings for those firms and their employees. On average, employees ended up with lower out-of-pocket costs of $317 for individuals and $1,355 for families. For companies, costs dropped an average of 12 percent.

Some Senators have theorized that MSAs would be harmful to the sick and to the poor. The Cleveland study showed that our colleagues' theories are wrong. Under MSAs, both individuals and families had to spend less in order to reach full reimbursement from their respective health insurance than did individuals and families with traditional insurance. For instance, under a traditional family plan, the average family had a $744 deductible and had to pay $1,444 in co-payments before reaching full reimbursement, for a total out-of-pocket cost of $2,188. In contrast, the average family with an MSA/high-deductible combination had employee MSA contributions of $1,167 and a $2,000 deductible, which gave it a total out-of-pocket cost of only $833. Thus, for anyone with a very ill family member, having an MSA instead of traditional insurance resulted in average savings of $1,355.

MSAs would be especially beneficial for poorer Americans because no co-payments would be necessary. If an employer put in $1,000 in a year into a low-income employee's MSA, and if that employee had only $500 in medical expenses, every penny of those expenses would be paid for out of the MSA. The employee would not pay anything. If that same employee had a traditional insurance plan, though, he would have co-payment and deductible costs. According to a Joint Tax Committee study, passing MSA provisions such as are in the Dole/Roth amendment would result in 78 percent of the benefits going to people making under $75,000. Considering the cost savings involved, we do not find this estimate surprising.

The benefits of MSAs do not stop with the savings. MSA participants also gain complete flexibility to use the money in their MSAs to select any doctors, dentists, ophthalmologists, or other health care professionals they wish for services. Under traditional health plans, services provided and the professionals who may be consulted are usually restricted; for instance, most plans sharply limit dental benefits. Yet another benefit is that MSAs result in individuals building up huge savings. Health economists Gail Jensen and Robert Morlock surveyed approximately 1 million individuals in 1989, and found that one-third filed no health insurance claim, 73 percent filed claims between $0 and $500, and 89 percent filed claims of less than $2,000. Assuming average annual expenses of $250, an MSA receiving the maximum $2,000 annual contribution would hold $9,821 after 5 years and $647,010 after 45 years. With average expenses of $1,000, an MSA receiving the maximum contribution would hold $5,068 after 5 years and $333,941 at retirement.

This bill will unquestionable increase insurance costs. That increase in costs will lead to calls for further reforms. Our liberal Democratic colleagues have candidly admitted that they expect those higher costs to build support for their proposals to increase the Government's control over the private health care industry. We think that they oppose MSAs, and have pressured conservative Democrats to oppose them as well, because they know that MSAs will lower medical costs and thus lower support for Federal controls.

We do not want to nationalize health care, and we see no reason for putting off the debate until the higher costs this bill will create bring Congress back to consider further reforms. MSAs eliminate the adversarial relationship between insurers and the insured, they lower costs for everyone, and they allow people to seek exactly the medical services they need from whomever they please. The benefits are so obvious that everyone, Democrat and Republican, supported MSAs until it occurred to liberals that MSAs would be so beneficial that they would make it difficult to gain support for nationalizing health care. Though we may not succeed on this vote, the concept is so meritorious that we are confident that this proposal will eventually pass. For now, we urge our colleagues to vote against the Kassebaum amendment to strike the MSA provisions from the Dole/Roth amendment.